EXHIBIT G

DELAWARE PSYCHIATRIC CENTER
Patient/Family Grievance, Concern or Suggestion Form

NAME: Jimmie Lewis DATE: 6-3-2004

UNIT: North ATTENDING PSYCHIATRIST: _____

DIRECTIONS: *In the space below, please state as clearly and specifically as possible your grievance, concern or suggestion. (Use additional pages if necessary.) If you need help in completing this form unit staff, pastoral services (255-2984) or a member of the Patient Rights Committee (255-2978) are available for assistance. Upon completion, return the signed and dated form to unit staff or directly to your psychiatrist.*

I HAVE BEEN GIVEN ANTI BIOTIC'S FOR UTI FOR FIVE DAYS. IM SURE THAT FIVE DAYS WORTH OF ANTI BIOTIC'S WILL NOT CLEAR UP THE UTI BECAUSE THE DR TRIED TO GIVE ME ANTI BIOT'S NAMED BACTRIM AND IT HAD TO BE GIVEN FOR AN ADDITIONAL FIVE DAYS.

RECEIVED
JUN 07 2004
PLANNING DEPARTMENT

Patient/Family Signature: Jimmie Lewis Date: 6/3/04

Received By: Raverne Conyer OSS. Date: 6/3/04

DIRECTIONS FOR STAFF: MC
Please make a copy of this sign/dated form and provide it to the patient/family member. Forward the original form immediately to the Treatment Team and fax a copy to the Clinical Risk Manager in the Department of Planning and Performance Improvement. (255-4418)

TREATMENT TEAM WRITTEN RESPONSE LEVEL II

Written response to be provided to the patient/family within one (1) working day.

Urinalysis (-) for UTI
Medical Doctor prescribed 5 day of Bactrim
~~urology~~ Consult to be ordered
By Dr Foster to further explain Symptoms

Treatment Team Representative Signature/Title: D Stachowski Date: 6/4/04

I, Jimmie Lewis am satisfied with this response: ☑ YES ☐ NO

Patient/Family Signature: Jimmie Lewis Date: _____

The patient/family MUST be provided with a copy of this response.

STAFF: *If the patient/family is NOT satisfied and/or refuses to sign, forward the original form immediately to the Unit Director and Fax a copy to the Clinical Risk Manager at 255-4418. All resolved grievance forms are forwarded to the Clinical Risk Manager, DPPI and a copy forwarded to the Patient Rights Committee Chairperson.*

HOSPITAL DIRECTOR/DESIGNEE WRITTEN RESPONSE LEVEL III

Written response to be provided to the patient/family within three (3) working days.

Hospital Director/Designee Signature/Title: _____ Date: _____

I, _____ am satisfied with this response: ☐ YES ☐ NO

Patient/Family Signature: _____ Date: _____

The patient/family MUST be provided with a copy of this response.

UNIT DIRECTOR: *Please forward a copy of this form to the Patient Rights Committee Chairperson and forward the original form immediately to Clinical Risk Management/DPPI.*

DELAWARE PSYCHIATRIC CENTER
Patient/Family Grievance, Concern or Suggestion Form

NAME: Jimmie Lewis DATE: 6/9/04

UNIT: North ATTENDING PSYCHIATRIST:

DIRECTIONS: *In the space below, please state as clearly and specifically as possible your grievance, concern or suggestion. (Use additional pages if necessary.) If you need help in completing this form unit staff, pastoral services (255-2984) or a member of the Patient Rights Committee (255-2978) are available for assistance. Upon completion, return the signed and dated form to unit staff or directly to your psychiatrist.*

I DONT EAT PORK AND VEAL OR PRODUCTS PRODUCED
ROM YEAST SUCH AS BREAD, CAKES, PANCAKES,
AFFLES AND FRENCH TOAST IN WHICH ARE ~~A~~ MAJORITY
THE FOOD SOURCE HERE. THESE ITEMS CAUSE ME
RITABLE BOWELS. I EXPLAINED TO THE DIETICIAN
AT I ALSO HAVE HIGH BLOOD PRESURE AS WELL
S LACTOSE INTOLERANT, BUT I CAN EAT CHEESE.
SINCE I HAVE BEEN RECEIVING THE CHEF SALAD
E HAVE BEEN ABLE TO AVOID SNACK FOODS
TAT CAUSE MY BLOOD PRESURE TO SPIKE OR RISE
J WITCH IN SOME WAY OR ANOTHER EFFECTS my
EHAVIOR. ALSO DUE TO my LIMITED SELECTION,
E ONLY RECEIVE A SMALL TRAY OF EGG AND A
RY BOX OF CEREAL FOR BREAKFAST, TO WITCH THE
SALAD HAD BALACED OUT

Patient/Family Signature: Jimmie Lewis Date: 6/9/04

Received By: Anne Lawrence, RN Date: 6/9/04

DIRECTIONS FOR STAFF:
Please make a copy of this sign/dated form and provide it to the patient/family member. Forward the original form immediately to the Treatment Team and fax a copy to the Clinical Risk Manager in the Department of Planning and Performance Improvement. (255-4418)

F

TREATMENT TEAM WRITTEN RESPONSE

LEVEL II

Written response to be provided to the patient/family within one (1) working day.

Your dietary needs will be assessed on an ongoing basis. You have been ordered a therapeutic diet based on your individual needs. Factors that will have an impact on the type of diet include: persoal food choices, Ideal body weight, and any medical condition. Please continue to request to the nurse when ever you feel that your needs are not being met. Thank you.

Treatment Team Representative Signature/Title: _____ Date: 6/10/04

I, Jamie Lewis am satisfied with this response: ☑ YES ☐ NO

Patient/Family Signature: _____ Date: 6/11/04

The patient/family MUST be provided with a copy of this response.

STAFF: *If the patient/family is NOT satisfied and/or refuses to sign, forward the original form immediately to the Unit Director and Fax a copy to the Clinical Risk Manager at 255-4418. All resolved grievance forms are forwarded to the Clinical Risk Manager, DPPI and a copy forwarded to the Patient Rights Committee Chairperson.*

HOSPITAL DIRECTOR/DESIGNEE WRITTEN RESPONSE

LEVEL III

Written response to be provided to the patient/family within three (3) working days.

Hospital Director/Designee Signature/Title: _____ Date: _____

I, _____ am satisfied with this response: ☐ YES ☐ NO

Patient/Family Signature: _____ Date: _____

The patient/family MUST be provided with a copy of this response.

UNIT DIRECTOR: *Please forward a copy of this form to the Patient Rights Committee Chairperson and forward the original form immediately to Clinical Risk Management/DPPI.*

RECEIVED
JUL 01 2004
PLANNING DEPARTMENT

DELAWARE PSYCHIATRIC CENTER
Patient/Family Grievance, Concern or Suggestion Form

NAME: Jimmie Lewis DATE: 6/9/04

UNIT: NORTH ATTENDING PSYCHIATRIST: DR. Foster

DIRECTIONS: *In the space below, please state as clearly and specifically as possible your grievance, concern or suggestion. (Use additional pages if necessary.) If you need help in completing this form unit staff, pastoral services (255-2984) or a member of the Patient Rights Committee (255-2978) are available for assistance. Upon completion, return the signed and dated form to unit staff or directly to your psychiatrist.*

FOR SEVEN YEARS I LET MY HAIR GROW NATURAL WITHOUT BRINGING A RAZOR/comb TO MY HAIR, IN WHICH IS THE LAW OF THE AZIRITE, RASTAFARIAN. SEE "THE HOLY BIBLE", THE BOOK OF NUMBERS CHAPTER 6. BUT THERE CAME A TIME THAT I CAME IN CONTACT WITH A DEAD PERSONS BODY, IN WHICH CAUSED ME TO COMMIT THE WRITTEN RITUAL OF CUTTING OFF AND OFFERING MY HAIR AS A BURNT SACRIFICE. AT THIS TIME I AM IN A INCERCRATED STATE SET APART FOR A HOLY PURPOSE; TO WHICH GIVES REASON TO WHY I NEED TO CONTINUE CUTING MY HAIR SPECIFICLY UNTIL MY VOW HAS RUN ITS COURSE.

Patient/Family Signature: Jimmie Lewis Date: 6/9/04

Received By: Donna Lawrence, RN Date: 6/9/04

DIRECTIONS FOR STAFF:
Please make a copy of this sign/dated form and provide it to the patient/family member. Forward the original form immediately to the Treatment Team and fax a copy to the Clinical Risk Manager in the Department of Planning and Performance Improvement. (255-4418)

PRO

TREATMENT TEAM WRITTEN RESPONSE

LEVEL II

Written response to be provided to the patient/family within one (1) working day.

As part of the Mitchell Building treatment program there is a barber scheduled every other Friday to provide hair cuts for our patients in the Mitchell Building. The shaving of heads with the plastic razors(disposable) is not permitted.

Thank You.

Treatment Team Representative Signature/Title: _____ Date: 6/10/04

I, _____ am satisfied with this response: ☐ YES ☑ NO

Patient/Family Signature: refused to sign _____ Date: _____

The patient/family MUST be provided with a copy of this response.

STAFF: *If the patient/family is NOT satisfied and/or refuses to sign, forward the original form immediately to the Unit Director and Fax a copy to the Clinical Risk Manager at 255-4418. All resolved grievance forms are forwarded to the Clinical Risk Manager, DPPI and a copy forwarded to the Patient Rights Committee Chairperson.*

HOSPITAL DIRECTOR/DESIGNEE WRITTEN RESPONSE

LEVEL III

Written response to be provided to the patient/family within three (3) working days.

Thanks - perhaps a compromise can be reached using the barber -

Hospital Director/Designee Signature/Title: _____ Date: _____

I, _____ am satisfied with this response: ☐ YES ☐ NO

Patient/Family Signature: _____ Date: _____

The patient/family MUST be provided with a copy of this response.

UNIT DIRECTOR: *Please forward a copy of this form to the Patient Rights Committee Chairperson and forward the original form immediately to Clinical Risk Management/DPPI.*

Patient discharged 6/25

DELAWARE PSYCHIATRIC CENTER
Patient/Family Grievance, Concern or Suggestion Form

NAME: Jimmie Lewis DATE: 6/20/04

UNIT: North ATTENDING PSYCHIATRIST:

DIRECTIONS: *In the space below, please state as clearly and specifically as possible your grievance, concern or suggestion. (Use additional pages if necessary.) If you need help in completing this form unit staff, pastoral services (255-2984) or a member of the Patient Rights Committee (255-2978) are available for assistance. Upon completion, return the signed and dated form to unit staff or directly to your psychiatrist.*

For the last past week or so I have
een trying to deal with the incident that
ppened in the dinning room, in which I
as assulted and chocked until I almost
ssed out by Mr Grey. My throat is
till sore. Ive tried to use the advise
e received from the classes, but I still
ve my mind on the incident constant.
I dont know how to deal with this

RECEIVED
JUN 29 2004
PLANNING DEPARTMENT

Patient/Family Signature: Jimmie Lewis Date: 6/20/04

Received By: Karen Chamblin Date: 6-20-04

DIRECTIONS FOR STAFF:
Please make a copy of this sign/dated form and provide it to the patient/family member. Forward the original form immediately to the Treatment Team and fax a copy to the Clinical Risk Manager in the Department of Planning and Performance Improvement. (255-4418)

PS

A-49

TREATMENT TEAM WRITTEN RESPONSE LEVEL II

Written response to be provided to the patient/family within one (1) working day.

These allegations are being investigated.

Treatment Team Representative Signature/Title: _____ Date: 6/21/04

I, Jimmie Lewis am satisfied with this response: ☑ YES ☐ NO

Patient/Family Signature: Jimmie Lewis Date: 6/29/04

The patient/family MUST be provided with a copy of this response.

STAFF: *If the patient/family is NOT satisfied and/or refuses to sign, forward the original form immediately to the Unit Director and Fax a copy to the Clinical Risk Manager at 255-4418. All resolved grievance forms are forwarded to the Clinical Risk Manager, DPPI and a copy forwarded to the Patient Rights Committee Chairperson.*

HOSPITAL DIRECTOR/DESIGNEE WRITTEN RESPONSE LEVEL III

Written response to be provided to the patient/family within three (3) working days.

Hospital Director/Designee Signature/Title: _____ Date: _____

I, _____ am satisfied with this response: ☐ YES ☐ NO

Patient/Family Signature: _____ Date: _____

The patient/family MUST be provided with a copy of this response.

UNIT DIRECTOR: *Please forward a copy of this form to the Patient Rights Committee Chairperson and forward th*
Clinical Risk Management/DPPI.

A--50

ABOVE MENTIONED INCIDENT REPORTED VIA IR. STATES THAT THE PT. WAS STRUCK BY DOOR (NOT CHECKED) THIS EVENT COINCIDES WITH

DELAWARE PSYCHIATRIC CENTER
Patient/Family Grievance, Concern or Suggestion Form

NAME: Jimmie Lewis DATE: 6/23/04

UNIT: North ATTENDING PSYCHIATRIST:

DIRECTIONS: *In the space below, please state as clearly and specifically as possible your grievance, concern or suggestion. (Use additional pages if necessary.) If you need help in completing this form unit staff, pastoral services (255-2984) or a member of the Patient Rights Committee (255-2978) are available for assistance. Upon completion, return the signed and dated form to unit staff or directly to your psychiatrist.*

Today I gave
Ms Cornish a name tag for clothing
with the name M- Rose. I found
he name tag inside of my room
ocker. At this point I can only
onder if this is a link to the reason
hy I am being told that me and
s M- Rose was involved in a incident
to which I am claiming that
omething was stolen from my room.

Patient/Family Signature: Jimmie Lewis Date: 6/23/04

Received By: [signature] Date: 6/23/04

DIRECTIONS FOR STAFF:
Please make a copy of this sign/dated form and provide it to the patient/family member. Forward the original form immediately to the Treatment Team and fax a copy to the Clinical Risk Manager in the Department of Planning and Performance Improvement. (25

A-51

TREATMENT TEAM WRITTEN RESPONSE

LEVEL II

Written response to be provided to the patient/family within one (1) working day.

This is a duplicated grievance. This issue was addressed in a prior complaint dated 6/23/04. Thank You.

Treatment Team Representative Signature/Title: _____ Date: 6/24/04

I, Pt discharge before review am satisfied with this response: ☐ YES ☐ NO

Patient/Family Signature: _____ Date: _____

The patient/family MUST be provided with a copy of this response.

STAFF: *If the patient/family is NOT satisfied and/or refuses to sign, forward the original form immediately to the Unit Director and Fax a copy to the Clinical Risk Manager at 255-4418. All resolved grievance forms are forwarded to the Patient Rights Committee Chairperson.*

HOSPITAL DIRECTOR/DESIGNEE WRITTEN RESPONSE

LEVEL III

Written response to be provided to the patient/family within three (3) working days.

Hospital Director/Designee Signature/Title: _____ Date: _____

I, _____ am satisfied with this response: ☐ YES ☐ NO

Patient/Family Signature: _____ Date: _____

The patient/family MUST be provided with a copy of this response.

UNIT DIRECTOR: *Please forward a copy of this form to the Patient Rights Committee Chairperson and forward the original form immediately to Clinical Risk Management/DPPI.*

RECEIVED
JUL 02 2004
PLANNING DEPARTMENT

DELAWARE PSYCHIATRIC CENTER
Patient/Family Grievance, Concern or Suggestion Form

NAME: Jimmie Lewis DATE: 6/23/04

UNIT: North ATTENDING PSYCHIATRIST:

DIRECTIONS: *In the space below, please state as clearly and specifically as possible your grievance, concern or suggestion. (Use additional pages if necessary.) If you need help in completing this form unit staff, pastoral services (255-2984) or a member of the Patient Rights Committee (255-2978) are available for assistance. Upon completion, return the signed and dated form to unit staff or directly to your psychiatrist.*

Staff person named Pat Riley
as passing by me in the hallway north unit directly
ter snack. I was talking about it seeming like
aximum security because we all were pat searched
al good. I then said I guess we will have to get
ipped searched next, were we will have to bend
e, and cough. then for no reason known to me?
t Riley said yea I know how you got your black
a locked up, with your faggot ass self, I know
ur not complaining about bending over you punk.
responded by saying who the fuck are you
lking too? Pat Riley replied by saying you
ald headed homosexual, I know all about you?
hats why your big ass head is bald so you
n wear a blonde wig, you fucker retarted
so transexual. Shortly after I seen Pat Riley by my
om, I went in and searched and found a tag M. Rose.

Patient/Family Signature: Jimmie Lewis Date: 6/23/04

Received By: [signature] Date: 6/25/04

55

DIRECTIONS FOR STAFF:
Please make a copy of this sign/dated form and provide it to the patient/family member. Forward the original form immediately to the Treatment Team and fax a copy to the Clinical Risk Manager in the Department of Planning and Performance Improvement. (255-4418)

TREATMENT TEAM WRITTEN RESPONSE

LEVEL II

Written response to be provided to the patient/family within one (1) working day.

The alleged incident outlined in this grievance was witnessed and documented by the nurse in charge. There was no noted inapropiate interaction with patient by the staffmember noted in this complaint. The name tag mentioned in this grievance was taken off the clothing of the male peer who was once on the north unit.
The male peer reports that he tore the tags off his own cloths and left the tag on the unit. Please continue to address staff and your peers in a respectful manner. Thank you.

Treatment Team Representative Signature/Title: _____ Date: 6/23/04

I, Pt discharged before review am satisfied with this response: ☐ YES ☐ NO

Patient/Family Signature: _____ Date: _____

The patient/family MUST be provided with a copy of this response.

STAFF: *If the patient/family is NOT satisfied and/or refuses to sign, forward the original form immediately to the Unit Director and Fax a copy to the Clinical Risk Manager at 255-4418. All resolved grievance forms are forwarded to the Clinical Risk Manager, DPPI and a copy forwarded to the Patient Rights Committee Chairperson.*

HOSPITAL DIRECTOR/DESIGNEE WRITTEN RESPONSE

LEVEL III

Written response to be provided to the patient/family within three (3) working days.

Hospital Director/Designee Signature/Title: _____ Date: _____

I, _____ am satisfied with this response: ☐ YES ☐ NO

Patient/Family Signature: _____ Date: _____

The patient/family MUST be provided with a copy of this response.

UNIT DIRECTOR: *Please forward a copy of this form to the Patient Rights Committee Chairperson and forward the original form immediately to Clinical Risk Management/DPPI.*

EXHIBIT H

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF DELAWARE

JIMMIE LEWIS,	)	
	)	
Plaintiff,	)	
	)	
v.	)	C.A. No. 04-1350-GMS
	)	
DR. SYLVIA FOSTER, et al.,	)	
	)	
Defendants.	)	

DEFENDANT ROBERT GRAY'S
RESPONSE TO PLAINTIFF'S MOTION FOR DEPOSITION ANSWERS

1. Robert Gray what is your specific account of what occurred at the D.P.C. Mitchell Building dinning hall on 6/14/04 at or about 8:00 pm, regarding the plaintiff Jimmie Lewis.

RESPONSE: I heard a code called over my walkie-talkie for all staff to assist in the Dining Hall, at or about 8:45 p.m. I came to the Dining Hall from the south side of the Mitchell Building. When I entered the Dining Hall, I saw Jimmie Lewis standing at a table eating M&M's. There was one patient seated at eth table where Lewis was standing. Nurse Helen Hanlon was seated, some distance away in the room, talking with Lewis. At least three other staff members (David Moffett, Michael Erickson, and William Evans) were already present standing several feet from Lewis. One of those three was talking with Lewis. Lewis continued to eat the candy and was yelling and cursing at staff. Lewis then drew back his right arm to throw a punch or elbow at the staff member who had been talking with him. When I saw Lewis go into a fighting stance, I moved towards Lewis, grabbed his left wrist with my left hand, and placed my right hand on his right shoulder area. I then pulled Lewis towards my body, and we fell to the floor together. Another staff member grabbed Lewis around his legs. On the floor, I asked Lewis if he was alright. Lewis still had candy in his mouth that he then spit out. At no time did I place my hands around his Lewis' throat. The other staff helped to secure his arms and legs. I asked Lewis if he would "contract for safety," to which he responded that he would. At that point, Lewis and I stood up together and other staff escorted him out of my presence. At no time during this incident did I observe any staff member punch or kick Lewis.

2. Robert Gray who were the D.P.C. personnel that escorted the plaintiff to the seclusion room on 6/14/04 at or about 8:00 pm

RESPONSE: I did not participate in the transport of Lewis from the Dining Hall to the seclusion room on June 14, 2004. I do not have personal knowledge of what staff conducted the escort.

3. Robert Gray what is the description of you job duties.

RESPONSE: I am a Nursing Assistant at the Delaware Psychiatric Center. I attend classes concerning facility policies and procedures, nursing, therapeutic support methods, and safety and security. I receive hands-on training by observing and assisting professional and higher level non-professional nursing and therapeutic staff. I monitor and record temperature, pulse, respiration, blood pressure, nutritional intake, and alert professional staff to significant irregularities. I implement prescribed treatment plans involving reality orientation, sensory stimulation, range of motion exercise, and the application of splints and braces. I provide oral and written descriptions of patients' physical and behavioral changes. I observe patients' activities, providing oral and written report of unusual and hazardous behavior. I observe and supervise patients within the facility and its surroundings to ensure appropriate location and security. I escort patients traveling to social and recreational activities and medical appointments off campus. I participate on the interdisciplinary care team providing information about patients' overall physical condition, abilities, and behavioral characteristics. I apply appropriate interventions to prevent or deescalate inappropriate behaviors. I assist patients with personal hygiene. I maintain patient surroundings ensuring appropriate infection control, sanitary conditions, care, and storage of linens and clothing. I perform additional security related work.

4. Robert Gray have you ever had to utilize force on a patient at the D.P.C.

RESPONSE: Yes.

5. Robert Gray while Dr. Foster was employed at the D.P.C. dating 5/21/04 to 6/25/04 did she have the authority to order you to utilize force on a patient.

RESPONSE: Yes.

6. Robert Gray have you ever filed grievance(s) regarding the description of your job duties at the D.P.C.

RESPONSE: No.

/s/_____
Robert Gray

STATE OF DELAWARE
DEPARTMENT OF JUSTICE

/s/_____
Gregory E. Smith, ID No. 3869
Deputy Attorney General
820 North French Street, 7th Floor
Carvel State Building
Wilmington, Delaware 19801
(302) 577-8398
Attorney for Defendants Johnson,
Moffett, Sagers, and Gray

Dated: April 9, 2007